Medicare General Information, Eligibility, and Entitlement

Chapter 1 - General Overview

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(Rev. 7, 06-25-04)

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10 - General Program Benefits - (Rev. 1, 09-11-02)

The Health Insurance for the Aged and Disabled Act (title XVIII of the Social Security Act), known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the nation's elderly to meet hospital, medical, and other health costs. Health insurance coverage has also been extended to persons under age 65 qualifying as disabled and those having end stage renal disease (ESRD) or Lou Gehrig's disease. The program includes two related health insurance programs--hospital insurance (HI) (Part A) and supplementary medical insurance (SMI) (Part B).

10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice and Skilled Nursing Facility (SNF) Services - A Brief Description - (Rev. 1, 09-11-02)

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider.

In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of posthospital extended care services. Under the latter benefit, the beneficiary must have been in a hospital receiving inpatient hospital services for at least 3 consecutive days (counting the day of admission but not the day of discharge) and be admitted to a SNF or to the SNF level of care in a swing bed hospital within 30 days after the date of hospital discharge. (Under certain circumstances, the 30 days may be extended.)

Where the person became entitled to HI at or after age 65, the hospital discharge must have occurred on or after the first day of the month in which he attained age 65. If his or her current entitlement began before age 65; i.e., he became entitled to HI under the disability or chronic renal disease provisions of the law, the hospital discharge must have occurred while he was so entitled. The 3 consecutive calendar days requirement can be met by stays totaling 3 consecutive days in one or more hospitals.

A SNF provides skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services. A SNF may be either a separate institution (e.g., a nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary of the Department of Health and Human Services (DHHS), and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified SNF has attempted in good faith but without success to enter into a transfer agreement, this requirement may be waived by the State agency.

For Medicare purposes, the term SNF does not include any institution which is primarily for the care and treatment of mental diseases . Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services, drugs, biologicals, supplies, appliances, and equipment; and other services ordinarily furnished by or under arrangements made by the facility. No payment may be made for items or services which would not be covered in a hospital, or for custodial care when that is the only type of care that the beneficiary needs.

The services of residents and interns of a hospital with which the facility has a swing bed "transfer" agreement and other diagnostic and therapeutic services furnished by such a hospital are covered, but only if billed through the SNF.

Under §4005(b)(2) of the Omnibus Budget Reconciliation Act of 1987, effective for swing bed agreements entered into after March 31, 1988, hospitals with more than 49 beds (but less than 100 beds) are subject to the following conditions. However, these conditions were eliminated by section 408 of the Balanced Budget Refinement Act of 1999 (BBRA), effective with the start of the facility's fourth cost reporting period that begins on or after July 1, 1998. (For those facilities that received no Medicare payment prior to October 1, 1995, this change is effective as of the date of BBRA's enactment, November 29, 1999.)

If there is an available SNF bed in the geographic region, the hospital must transfer the extended care patient within 5 days of the availability date (excluding weekends and holidays) unless the patient's physician certifies within that 5-day period, that transfer of that patient to that facility is not medically appropriate on the availability date. In order to do this, the hospital must identify all SNFs in the geographic region and enter into agreements with them for the transfer of extended care patients. The agreement must call for the SNF to notify the hospital of the availability of beds and the dates these beds will be available for extended care patients.

For each cost reporting period, payment may not be made for patient days of extended care services that exceed 15 percent of the total number of available patient days (except that such payment shall continue to be made for those patients who are receiving extended care services at the time the hospital reaches the 15% limit). The limit is calculated by multiplying the average number of licensed beds by the total number of days in the cost reporting period.

Hospitals having fewer than 50 beds and rural hospitals which entered into transfer agreements before March 31, 1988 (i.e., those which were licensed for more than 49 beds but who were operating as a 50 or less bed facility), are not subject to the 5-weekday transfer requirement or the payment limitation for extended care days. (See section 2230.10 of the Provider Reimbursement Manual, Part 1, for the explanation of the payment limitation.)

"Geographic region" is an area which includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area which includes all the SNFs within 50 miles of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether a SNF is within this region or the SNF is inaccessible to hospital patients, the CMS regional office shall make a determination.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

10.2 - Home Health Services - (Rev. 1, 09-11-02)

To qualify for home health benefits under either Part A or Part B of the program, a beneficiary must be confined to his/her home, under the care of a physician, and in need of skilled nursing services on an intermittent basis, physical therapy, or speech therapy. Being "confined to the home" does not mean a beneficiary can never leave the home. See Chapter 7 of the Benefit Policy publication for the definition of homebound. A beneficiary who requires one or more of these services in the treatment of his/her illness or injury and otherwise qualifies for home health benefits is eligible to have payment made on his/her behalf for the skilled nursing, physical or speech therapy he needs, as well as for any of the other home health services specified in the law. These services include occupational therapy, medical social services, the use of medical supplies and medical appliances, and the part-time or intermittent services of home health aides. Conversely, a patient who does not require intermittent skilled nursing or physical or speech therapy cannot qualify to have payment made under the program for any home health services furnished him. Excluded as home health services are the costs of housekeepers, food service arrangements, and transportation to outpatient facilities.

To be covered, the home health services must be needed for a condition for which the patient required inpatient hospital services or extended care services. See the Chapter 7 of the Benefit Policy publication for a description of services covered. Discharge from the hospital must have occurred in a month in which the patient has attained age 65 or was entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs. To participate in the health insurance program, a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of the Department of Health and Human Services. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases; such an agency may qualify only under supplementary medical insurance.

Home health services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, SNF, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

The services of an intern or resident-in-training are covered if the agency has an affiliation with or is under common control of a hospital providing such medical services and the agency bills for such services.

Prior to July 1, 1981, home health services under hospital insurance included up to 100 home health visits, after the beginning of one benefit period and before the beginning of the next. The visits must have been furnished to a patient within 1 year of his/her most recent discharge from a hospital where he was an inpatient for at least 3 consecutive calendar days (counting the day of admission, but not the day of discharge). If, after his/her hospitalization, he had a covered stay in a SNF, the 1 year during which the patient may receive home health services began with the discharge from the SNF. A plan of treatment must have been established within 14 days after the hospital or SNF discharge. Home health services were also provided under supplementary medical insurance where the 100-visit limit under Part A was exceeded.

Effective July 1, 1981, the 100-visit limitation under Parts A and B, and the prior inpatient stay requirement under Part A were eliminated. In addition, a person could qualify for home health services based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech therapy, or occupational therapy. Effective December 1, 1981, occupational therapy was eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical or speech therapy, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy.

Effective January 1, 1998, the first 100 visits must be paid under Part A if the beneficiary is entitled under Part A, and the remainder of the visits may be paid under Part B.

10.3 - Supplementary Medical Insurance (Part B) - A Brief Description - (Rev. 1, 09-11-02)

To obtain SMI, an eligible individual must enroll during an enrollment period and pay the required premiums. An individual is eligible to enroll if they are entitled to HI or are 65 years of age and a citizen or resident alien who meets certain residence requirements. SMI provides for payment to participating providers for furnishing covered services after a yearly cash deductible is met. The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for home health visits not available under hospital insurance (e.g., no Part A entitlement or visits after the first 100 visits) and for medical and other health services. Payment may not be made under Part B for any service that may be paid under Part A. However, where payment is not possible under Part A (e.g., no Part A entitlement or benefits are exhausted) payment may be made under Part B if the service is covered.

Subject to coverage and limitations described in the Benefit Policy Publication, the following services are covered under Part B.

- Physicians' services;
- Services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

- Hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;
- Diagnostic services which are-- (i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;
- Outpatient physical therapy services and outpatient occupational therapy services;
- Rural health clinic services and Federally qualified health center services;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1) of the Act, for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;
- Services furnished pursuant to a contract under section 1876 of the Act to a member of an eligible organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his/her service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and, services furnished pursuant to a risk-sharing contract under section 1876(g) of the Act to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker, and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;
- Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;
- Prescription drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for which payment is made under this title;
- Services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service; and but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.
- Services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services

and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

- Certified nurse-midwife services;
- Qualified psychologist services;
- Clinical social worker services;
- Erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;
- Prostate cancer screening tests;
- An oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered if the drug could not be self-administered;
- Colorectal cancer screening tests;
- Diabetes outpatient self-management training services;
- An oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)-- (i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and (ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;
- Screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;
- Medical nutrition therapy services in the case of a beneficiary with diabetes or a renal disease who-- (i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary; (ii) is not receiving maintenance dialysis for which payment is made under section 1881 of the Act; and (iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;
- Diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act), diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; Durable medical equipment;
- Ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;
- Prosthetic and orthotic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;
- Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;
- Vaccines: (1) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, (2) influenza vaccine and its administration; and (3) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B;

NOTE: A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

NOTE: For Medicare program purposes, the hepatitis B vaccine may be administered upon the order of a doctor of medicine or osteopathy by home health agencies, SNFs, renal dialysis facilities (RDFs), hospital outpatient departments, persons recognized under the "incident to physicians' services" provision of law, and, of course, doctors of medicine and osteopathy.

- Services of a certified registered nurse anesthetist;
- Subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if-- (1) the physician who is managing the individual's diabetic condition (a) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (b) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition; (2) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and (3) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in (1) above (unless the Secretary finds that the physician is the only such qualified individual in the area);
- Screening mammography;
- Screening pap smear and screening pelvic exam; and
- Bone mass measurement.
- No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an

institution considered a hospital for purposes of section 1814(d)) of the Act shall be included unless such laboratory-

1. Is situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (1) is licensed pursuant to such law, or (2) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing;

2. Meets the certification requirements under section 353 of the Public Health Service Act; and

3. Meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified any item or service which would not be included if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) of the Act shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

10.4 - Basis for Payment - (Rev. 1, 09-11-02)

(See Claims Processing, Pub 100-4 for a description of the basis for payment for the various services.)

20 - Administration of the Medicare Program - Introduction - (Rev. 1, 09-11-02)

The conduct of the program has been delegated by the Secretary of the Department of Health and Human Services to the Administrator of the Centers for Medicare & Medicaid Services (CMS). Congress has also provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law does not permit the Federal Government to exercise supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him/her services. The responsibility for treatment and the control of care remains with the individual's physician and the hospital or other facility or agency furnishing services. The individual may keep or obtain any other health insurance he/she desires including the choice to enroll in a Medicare+Choice plan. More information about Medicare+Choice plans is in the Medicare Managed Care Manual .

20.1 - Financing the Program - (Rev. 1, 09-11-02)

Part A is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund, which is used only for hospital insurance benefits and administrative expenses. Federal employees and State and local employees who do not pay the full FICA tax

must pay the HI portion; they are not eligible for monthly Social Security or railroad retirement benefits. The cost of providing Part A benefits to other persons who are not Social Security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B is financed by monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund is used only to pay for Part B benefits and administrative expenses.

20.2 - Discrimination Prohibited - (Rev. 1, 09-11-02)

Participating providers of Part A services under the supplementary medical insurance program (e.g., hospitals, SNFs, HHAs, hospices, outpatient physical therapy (OPT), comprehensive outpatient rehabilitation facilities (CORFs), occupational therapy and speech pathology providers, and renal dialysis facilities) must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating provider is prohibited from making a distinction on the grounds of race, color, or national origin, in the treatment of patients, the use of equipment, other facilities, and the assignment of personnel to provide services.

DHHS is responsible for investigating complaints of noncompliance.

20.3 - Fraud and Abuse - General - (Rev. 1, 09-11-02)

Providers and suppliers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud and abuse committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, there is also a range of administrative sanctions (such as exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Following are definitions and examples of fraud and abuse. These definitions and examples give a better understanding of the types of practices that are forbidden, under law, in the Medicare program.

20.3.1 - Definition and Examples of Fraud - (Rev. 1, 09-11-02)

Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the Government, it is necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally.

Examples of fraud include, but are not limited to, the following:

- Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;

- Altering claims forms and/or receipts in order to receive a higher payment amount;
- Duplicating billings that includes billing both the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than allowed;
- Offering, paying, soliciting, or receiving bribes, kickbacks, or rebates, directly or indirectly, in cash or in kind, in order to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program;
- Falsely representing the nature of the services furnished. This encompasses describing a noncovered service in a misleading way that makes it appear as if a covered service was actually furnished;
- Billing a person who has Medicare coverage for services provided to another person not eligible for Medicare coverage; and
- Using another person's Medicare card to obtain medical care.

20.3.2 - Definition and Examples of Abuse - (Rev. 1, 09-11-02)

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally.

Following are three standards that CMS uses when judging whether abusive acts in billing were committed against the Medicare program:

- Reasonable and necessary;
- Conformance to professionally recognized standards; and
- Provision at a fair price.

Examples of abuse include, but are not limited to, the following:

- Charging in excess for services or supplies;
- Providing medically unnecessary services or services that do not meet professionally recognized standards;
- Billing Medicare based on a higher fee schedule than for non-Medicare patients;
- Submitting bills to Medicare that are the responsibility of other insurers under the Medicare secondary payer (MSP) regulation; and
- Violating the participating physician/supplier agreement.

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice.

30 - Federal Government Administration of the Health Insurance Program - (Rev. 1, 09-11-02)

DHHS has overall responsibility for administering the hospital insurance and voluntary SMI programs. Two major agencies - CMS and the Public Health Service - are involved in specified administrative functions.

30.1 - CMS Responsibilities - (Rev. 1, 09-11-02)

CMS is responsible for policy formulation. The central and regional offices are responsible for the general management and operation of the program. In brief, CMS's responsibilities include the following:

- Determining an individual's entitlement to benefits in consultation with the Social Security Administration (SSA);
- Determining the nature and duration of services for which a beneficiary's benefits may be paid;
- Establishing, maintaining, and administering agreements with State agencies, providers of services, and intermediaries;
- Establishing operational policy for contractors;
- Developing operational instructions and official interpretations of policy for contractors;
- Formulating major policies regarding conditions of participation for providers in consultation with the Public Health Service;
- Developing and maintaining statistical research and actuarial programs; and
- Managing general finances of the program; and
- Managing the Medicare Premium Collection Operation.

CMS Regional Offices are responsible for assuring that contractors meet applicable Federal requirements under the provisions of their contracts. They also:

- Provide liaison, direction, and technical assistance to contractors in the day-to-day management of their operations;
- Interpret CMS guidelines, policies, and procedures applicable to contractor activities;
- Analyze contractor budgets and spending patterns to assure that funds are economically and appropriately utilized;
- Conduct assessments of contractor operations;
- Review contractor actions; and
- Provide feedback to each contractor.

30.2 - Public Health Service Responsibilities - (Rev. 1, 09-11-02)

The Public Health Service is responsible for administering the professional health aspects of the program. In brief, its responsibilities include the following:

- Consulting and recommending to CMS matters concerning the development of health and safety standards and other guidelines needed for determining whether providers of services meet the conditions of participation under the program;
- Consulting and advising State agencies concerning the application of standards for providers; and
- Coordinating programs and activities necessary in studying the utilization of services under the program.

30.3 - State Agencies - (Rev. 1, 09-11-02)

The States, by agreement with the Secretary, are assigned significant administrative functions to the extent that each is willing and capable of discharging such responsibilities.

30.3.1 - Certification by State Agencies - (Rev. 1, 09-11-02)

Facilities desiring to participate in either the Medicare or Medicaid programs must meet participation conditions for certification. State agencies certify to DHHS whether providers satisfy, and continue to satisfy, their respective conditions of participation in the Medicare and Medicaid programs. The Secretary, DHHS, certifies facilities requesting participation in the Medicare and Medicaid programs. States certify those facilities that request participation in the Medicaid program only.

The State function of making certifications is intended to be a natural adjunct to ongoing State activities (such as the licensing of health care facilities and the setting of standards).

30.3.2 - Consultation by State Agencies - (Rev. 1, 09-11-02)

A State consults with providers of services that need and request participation condition assistance. For Medicare participation, the Secretary, DHHS, must approve the consultation service rendered by the State certifying agency.

30.3.3 - Coordination by State Agencies - (Rev. 1, 09-11-02)

A State coordinates activities with other State programs that involve payment for health care, quality of care, and location of health facilities. Coordinating these activities is essential in assuring effective and economical use of existing State facilities and trained personnel and to prevent duplication of effort.

40 - Role of Part A Intermediaries - (Rev. 1, 09-11-02)

The Part A intermediary is a public or private agency or organization that has entered into an agreement with CMS to enroll legitimate providers into the Medicare program and process Medicare claims under both Part A and Part B services under the supplementary medical insurance program (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPTs, occupational therapy, and speech pathology providers, and ESRD facilities).

Intermediaries make payments to providers. The amount of payment to a provider is restricted to the lower of the billed charge, the reasonable cost of covered services or the fee schedule amount. Hospices are paid on a per diem amount that is prospectively set. SNFs and HHAs are paid based on a Prospective Payment System (PPS). (See Provider Reimbursement Manual, Part 1, §§2800ff.)

Hospitals are paid based on the PPS. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. This statement applies to inpatient for acute care hospitals and to inpatient rehabilitation hospitals. Whereas inpatient acute and rehab PPS payment is based on the discharge date, Outpatient PPS (OPPS) payments are based on Ambulatory Patient Classification payment for the date of service.

The amount of payment to other types of providers is restricted to the lesser of (a) the reasonable cost of covered services and items; or (b) the billed charges with respect to such services; or (c) the fee schedule amount.

In addition, intermediaries assist in applying safeguards against unnecessary use of covered services, furnish consultative services to serve as a center for communicating with providers, conduct audits of provider records, assist in the beneficiary appeals process, and provide information and advice to institutions and organizations that wish to qualify as providers of services.

(See cms.hhs.gov/medicare/incardir.htm for a list of intermediaries and service areas.)

40.1 - Election of Intermediary

Except for HHAs, hospices and freestanding CORFs, providers may elect to be served by an intermediary authorized to serve other providers in its area. Elections are reviewed by the RO and approved unless special or temporary limitations have been placed on the elected intermediary's availability, or an addition to the elected intermediary's workload at the time would be undesirable.

The RO sends the official notice to the contractor of changes in the contractor's list of providers.

40.2 - Intermediary Service to HHAs

Under 42 CFR 421.117, CMS is authorized to designate intermediaries to service HHAs and hospices. This provision was implemented through the designation of regional and alternative regional intermediaries to service all HHAs and hospices within the respective intermediary's jurisdictional boundaries. The list of Regional Home Health Intermediaries (RHHIs) and their service areas can be found at the following CMS Web site address:

http://cms.hhs.gov/medicare/incardir.htm#4

In the case of HHAs and hospices based in another Medicare provider (e.g., a hospital or SNF), audit, cost report settlement, and other fiscal functions (such as setting interim payment rates) are performed by the intermediary serving the parent provider.

While RHHIs have been designated to service all HHAs and hospices, CMS has designated an alternative regional intermediary. Where HHAs or hospices can demonstrate that it is in the best interest of the Government for them to not be serviced by the designated RHHI, the provider may request (through the CMS Regional Office) to be serviced by the designated alternative regional intermediary. The following are the designated alternative regional intermediaries and their respective jurisdictions.

Blue Cross and Blue Shield of Alabama.	Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, the Virgin Islands, Virginia, Washington, West Virginia, and Wisconsin.
Blue Cross and Blue Shield United of Wisconsin	Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming.

50 - Role of Part B Carriers - (Rev. 1, 09-11-02)

The law requires the Secretary, DHHS, to enter into contracts with carriers to serve in the operation and administration of the non-provider Part B program. Carriers enroll physicians, non-physician health care practitioners and other entities that will submit claims to the carrier, and process Medicare claims and make payments for services and supplies covered by Part B. Other major functions include, for example, controlling over-utilization and communicating with beneficiaries and the health community.

Durable Medical Equipment (DME) Regional Carriers have been given the responsibility of processing durable medical equipment, prosthetic, orthotic, and supply (DMEPOS) claims. See Claims Processing Manual Chapter 1 for description of jurisdiction.

60 - Background and Responsibilities of the Peer Review Organization (PRO) - (Rev. 1, 09-11-02)

Section 1153 of the Social Security Act (the Act) requires the Secretary to enter into contracts with physician-approved or physician-access organizations defined as PROs.

PROs are organizations who are responsible for monitoring the quality of care provided to Medicare patients by hospitals, SNFs, home health agencies, Medicare+Choice plans, and other types of health care providers.

PRO review is governed by titles XI and XVIII of the Act as amended, and by regulations contained in:

- 42 CFR 411 - Limitation on liability;
- 42 CFR 412 - Outlier review, diagnosis related group (DRG) validation, and hospital notices of non coverage;

- 42 CFR 417.605 - Immediate PRO review of Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP) notices of discharge;
- 42 CFR 422.622 - Immediate review of Medicare+Choice discharge notices;
- 42 CFR 475 - Definition of eligible organizations and area designation;
- 42 CFR 476 - Assumption and conduct of review;
- 42 CFR 478 - PRO reconsideration and appeals;
- 42 CFR 480 - Disclosure of information;
- 42 CFR 482 - Hospital conditions of participation; and
- 42 CFR 1004 - PRO recommendations of sanctions.

60.1 - Purpose of PRO Review for the Individual Medicare Beneficiaries - (Rev.)

PROs review items or services provided to Medicare beneficiaries to determine:

- Whether services provided or proposed to be provided are reasonable and medically necessary for the diagnosis and treatment of illness or injury, or to improve functioning of a malformed body member, or for prevention of an illness, or for the palliation and management of terminal illness;
- Whether those services furnished or proposed to be furnished on an inpatient basis could be effectively furnished on an outpatient basis, or in an inpatient health care facility of a different type;
- Medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of PPS;
- Whether a hospital has misrepresented admission or discharge information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries, or billing for services furnished to beneficiaries;
- The validity of diagnostic and procedural information supplied by the provider to the fiscal intermediary for payment purposes;
- The completeness and adequacy of hospital care provided; and
- Whether the quality of services meets professionally recognized standards of health care.

These activities enable PROs to determine whether Medicare payment may be made for the services claimed and to identify and initiate corrective action where appropriate. PROs have the authority to deny Medicare payment for medically inappropriate and unnecessary admissions. They also investigate individual beneficiary complaints about the quality of care received.

60.2 - PRO Responsibility for the Overall Approach to Health Care - (Rev. 1, 09-11-02)

In addition to individual case review, PROs also help providers improve the overall approach to health care for Medicare beneficiaries.

This function includes the following activities:

- Using clinical and other data bases to examine patterns of care and outcomes, rather than focusing on isolated cases;
- Identifying systemic variations of concern or interest by monitoring patterns of care and outcomes;
- Working with providers to identify provider-specific root causes of systemic variations; and
- Working cooperatively with the health care community to measurably improve the processes and outcomes of care for Medicare beneficiaries.

60.3 - Other PRO Responsibilities - (Rev. 1, 09-11-02)

A. Responsibilities Prior to Review
PROs are responsible for:

- Specifying in their plan and instructions to practitioners and providers the type of evidence they require to document the care ordered or furnished to provide medically necessary, appropriate, and quality health care services; and
- Applying professionally developed criteria for providing care, diagnosis, and treatment based upon typical patterns of practice within their geographic area to evaluate the medical necessity, quality, or appropriateness of services ordered or furnished.

B. Ongoing Review Activities

As a part of their ongoing review activities, PROs must:

- Notify the appropriate agency of the State or Federal government when they become aware of situations which appear to be improper, but which do not fall within their review responsibilities (e.g., poor quality care in a renal dialysis center);
- Use their authority or influence to enlist the support of other professional or Government agencies to ensure that all providers and practitioners for which they have review responsibilities comply with their obligations (see §1156 of the Act.); and
- Perform beneficiary and physician outreach activities.

C. Responsibilities as a Result of PRO Review

To act upon information they obtain as a result of their review activities, PROs must:

- Provide information on results of their review (e.g., annual report, periodic meetings with providers/practitioners);

- Identify and seek correction of situations that, if continued, would result in violations under §1156 of the Act;
- Submit reports to the Office of the Inspector General on providers and practitioners found to have substantially violated an obligation in a substantial number of cases, or to have grossly and flagrantly violated an obligation in one or more instances. This includes referring certain cases to State licensing boards.

D. Additional Activities

PROs perform all other activities specified in the Scope of Work, including any modifications, CMS regulations and instructions, and relevant statutory provisions.

E. Payment Error Prevention Program (PEPP)

In order to reduce inpatient PPS payment errors, PROs must initiate a program of Payment Error Prevention Projects (PEPPs). CMS defines the payment error rate as the number of dollars found to be paid in error out of the total of all dollars paid for inpatient PPS services. CMS provides State-specific error rates to PROs to evaluate performance.

60.4 - Statutory Obligations of Practitioners and Other Persons

It is the obligation of any health care practitioner or other person who furnishes or orders health care items or services that may be reimbursed under Medicare, to ensure that to the extent of his or her authority, those services are:

- Furnished economically and only when and to the extent medically necessary;
- Of a quality that meets professionally recognized standards of health care; and
- Supported by evidence of the medical necessity and quality of the services in the form and fashion that the reviewing PRO may reasonably require (including copies of the necessary documentation) to ensure that the practitioner or other person is meeting the obligations imposed by Section 1156(a) of the Act.

These obligations apply whether payment is made directly to the provider (i.e., assignment) or to the beneficiary, or even if payment is not made.

60.5 - Responsibilities of Designated Agents Working With PROs; Organizations Subcontracted for Review - (Rev. 1, 09-11-02)

The PRO has ultimate responsibility for monitoring the compliance of practitioners and providers with statutory obligations. It is not relieved of any of the responsibility under the sanction regulations in the event of non-performance by an organization with which it has subcontracted for review.

An organization with which the PRO subcontracts to carry out review functions is responsible for:

- Ensuring that practitioners and other persons meet their obligations with respect to the items and services it reviews; and
- Reporting to the PRO (primary contractor) those instances where it appears a violation of an obligation may have occurred or is occurring.

70 - Institutional Planning and Budgeting - (Rev. 1, 09-11-02)

The Social Security Act requires each provider, as a condition of participation under Medicare, to have a written overall plan and budget reflecting an annual operating budget and a capital expenditures plan (that covers at least a 3-year period including the year to which the operating budget is applicable). For this requirement, provider means hospital, critical access hospital, SNF, comprehensive outpatient rehabilitation facility, home health agency, or hospice program.

The annual operating budget will include all anticipated income and expenses related to items which would under generally accepted accounting principles be considered income and expense items. The capital expenditure plan would be expected to include and identify in detail the anticipated sources of finance for, the objectives of, each anticipated expenditure in excess of $l00,000 related to acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items.

The overall budget and plan will be prepared under the direction of the provider's governing body by a committee consisting of representatives of the governing body, administrative staff and if any, the medical staff. Further, it will be reviewed and updated at least annually. The purpose of the requirement is to assure that providers carry on budgeting and substance by the Government or any of its agents.

80 – CMS Managed Modules for Software Programs and Pricing/Coding Files

(Rev.2, 2-6-04)

The CMS Managed Modules contains scheduled release dates for software programs and pricing/coding files.

Medicare contractors will be receiving subsequent quarterly updates of the CMS Managed Modules via a Recurring Update Notification.